Please Return by June 30, 2009 to Remain on Program

END STAGE RENAL DISEASE PROGRAM

2009 Confidential Financial Statement

APPLICANT'S INFORMATION

Name _____
Last First MI

Physical Address _____
Number/Street/Apt. City State ZIP Code

Mailing Address _____
Number/Street/Apt. City State ZIP Code

Birth Date _____ Gender: Male / Female

Telephone Number ( ) _____

Number of persons in household _____ Relationship to applicant _____

APPLICANT'S PERSONAL INCOME	**OTHER HOUSEHOLD PERSONAL INCOME**
Employer / Occupation _____	Employer / Occupation _____
City/State _____	City/State_____
Gross Earnings from Employer $_____	Gross Earnings from Employer $_____
Monthly Social Security $_____	Monthly Social Security $_____
Monthly Retirement Income $_____	Monthly Retirement Income $_____
Monthly Disability Income and Source $_____ _____	Monthly Disability Income and Source $_____ _____
Monthly Income any other Source $_____	Monthly Income any other Source $_____
Total Gross Income Last Year $_____	**Total Gross Income Last Year $_____**
➔ **Attach a Filed Copy of your 2008 Income Tax Return if you do not file, then a copy of your Benefit Letter from Social Security for the current year or any other documentation of income if not taxable.**	➔ **Attach a Filed Copy of your 2008 Income Tax Return if you do not file, then a copy of your Benefit Letter from Social Security for the current year or any other documentation of income if not taxable.**

BUSINESS, FARM, OR OTHER INCOME	**Amount $**
Yearly Farm or business Income (if listed, please attach an itemized statement of business income and expenditures).	
Yearly Income from any sources other than shown above (rental property you own, dividends, welfare, unemployment compensation, per capita payments, part - time, second jobs, child support, etc.).	

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2009 FINANCIAL DATA
Monthly Medical Expenses

Applicant's Medical Payments

	Monthly Payment	Balance Owed
Physician		
Hospital		
Dental		
Prescriptions		
Other Medical Only (list)		
Other Medical Only (list)		
Other Medical Only (list)		
Other Medical Only (list)		

Assets (Applicant and Spouse)

Estimated Market Value of Home	
Value of Other Real Estate	
Stocks and/or bonds (name and value)	
Name of Bank	
Amount in Savings	
Amount in Checking	
Farm or business equipment value	
Other Assets (Type and Value)	

I (Applicant)_____ am applying for assistance from the End Stage Renal Disease Program, Department of Health. I am unable to pay for the recommended treatment. I will apply any hospital and or medical insurance and Medicare and/or Medicaid benefits I receive to the cost of my care. I will pay Medicare and/or Medicaid and other insurance premiums to provide coverage. I understand that the End Stage Renal Disease Program must give prior authorization for any care for which it is to pay.

All information I have given on this confidential financial statement and application is true to the best of my knowledge.

Signed_____ Date_____

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2009 Health Insurance Update

A. **Do you have private health insurance?** ☐ Yes ☐ No If yes, please complete the following information and attach copies (front and back) of your insurance cards.

Health Insurance Company Name	Type of Coverage	Effective Date	Policy Number
Monthly Premiums (Applicant only)	**$**		

B. **Do you have Medicare coverage?** ☐ Yes ☐ No If yes, please complete the following information and attach copies (front and back) of your Medicare card.

Type of coverage (check each box that applies)	Effective Date	Medicare ID Number
Part A ☐ Part B ☐ Part D ☐		
Monthly Premiums	Part B **$**	Part D **$**

C. **Do you have Medicaid coverage?** ☐ Yes ☐ No If yes, please complete the following information and attach copies (front and back) of your Medicaid card.

Type of Coverage	Effective Date	Medicaid ID Number

D. **Do you have Indian Health coverage?** ☐ Yes ☐ No If yes, attach a copy (front and back) of your Indian Health card.

Dialysis Center Information

Please complete the information below

Dialysis Center Name:			
Address:			
City:	**State:**	**Zip:**	
Social Worker Name:			
Phone Number:			
E-Mail:			

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CHECK LIST

HAVE YOU:

- ☐ **Filled out the financial update completely;**
- ☐ **Signed and dated your financial update;**
- ☐ **Included a photocopy of your 2008 income tax return;**
- ☐ **Included proof of income;**
- ☐ **Included Social Security statements;**
- ☐ **Included photocopies of all your health coverage identification cards;**
- ☐ **Completed your dialysis center information;**
- ☐ **Included your physical address along with your mailing address.**

Your financial update will be returned to you if the above information is not included.

State of Wyoming – Department of Health – Rural and Frontier Health Division
End Stage Renal Disease Program
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